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Office of Administrative Law Judges
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Issue Date: 10 March 2006

CASE NO.: 2003-BLA-6405

In the Matter of

BEN L. STEPHENSON (deceased),
Claimant

v.

ISLAND CREEK COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

DECISION AND ORDER ON REMAND — DENYING BENEFITS

This matter is before me on remand from the Benefits Review Board ("Board"). By Decision and Order Awarding Benefits dated September 24, 2004, I awarded benefits to the Claimant, finding that he had established that he was totally disabled due to pneumoconiosis. Employer appealed the Decision to the Benefits Review Board, challenging my findings. Employer contended that I erred in excluding certain x-ray readings from the record pursuant to §§ 725.414 and 725.456, that I improperly weighed the x-ray and medical opinion evidence under §§ 718.202(a)(1) and (a)(4), and that I improperly weighed the disability causation evidence under § 718.204. Claimant responded and urged affirmance of the award of benefits. The Director, Office of Workers' Compensation, filed a limited response, setting forth that the excluded x-ray evidence was properly excluded. In an unpublished opinion dated June 22, 2005, the Board affirmed the exclusion of the x-ray evidence but vacated the findings of pneumoconiosis and total disability due to pneumoconiosis and remanded the case for an accurate characterization of the relevant evidence and an adequate rationale for all my findings.[1]

Specifically, the Board held that I reconsider the medical opinions and CT scan readings, in addition to the x-ray evidence, to determine whether claimant had established the existence of either clinical or legal pneumoconiosis by a preponderance of the evidence. Should I find the existence of the disease, I must then consider whether claimant had established that he was totally disabled due to pneumoconiosis pursuant to § 718.204(c).

[1] Claimant died on May 2, 2005 while this case was pending before the Benefits Review Board.

X-ray Evidence Under § 718.202(a)(1)

The Board held that I did not provide an adequate explanation for my finding that claimant established the existence of pneumoconiosis under § 718.202(a)(1). The Board pointed out that I used three separate methods to assess the x-ray evidence: discussing each x-ray separately with regard for the qualifications of the reader, identifying the total number of positive and negative readings, and breaking down the number of positive and negative readings by each category of reader. The Board found, however, that I did not actually identify the method of weighing the x-ray evidence used to make my ultimate findings. Thus, I was directed on remand to address both the quantity and quality of the films of record, including the readers' qualifications, and to provide the rationale for my findings. Regarding the qualifications of Dr. Zaldivar, I was directed to address the physician's testimony of his B-reader status.

Chest X-rays

Exhibit No.	**X-ray Date**	**Physician/ Qualifications**	**Interpretation**
DX 1	8/24/73	Gaylor/BCR, B	0/0
DX 1	8/24/73	*Illegible*	1/0
DX 1	9/14/78	Kwak/BCR	1/1
DX 1	12/22/80	Goerlich/BCR, B	1/1
DX 1	8/29/84	Gaziano/B	Completely negative
DX 1	8/29/84	Daniel	2/2
DX 1	12/13/84	Bassali/BCR, B	3/3
CX 2-5	12/13/99	Shah/BCR	Severe degree of chronic obstructive pulmonary disease and pulmonary fibrosis
CX 2-4	3/20/01	Amin/B	Status post surgery of heart from coronary bypass surgery with severe chronic obstructive lung disease. Diffuse, fine honeycombing noted in both lung bases and periphery of lungs from small airway disease

CX 2-3	4/2/01	Amin/B	Status post surgery of heart from coronary bypass surgery with severe chronic obstructive lung disease; diffuse fine reticular nodular fibrosis in both lungs predominant in left periphery of left lung
CX 2-2	10/23/01	Amin/B	Status post surgery of heart from coronary bypass surgery with chronic obstructive lung disease. Diffuse, fine interstitial fibrosis is noted in both lungs from COLD
DX 14	11/2/01	Walker	2/2; p/q
DX 17 & 18	11/2/01	Hayes/BCR, B	2/2; p/q; 6 zones; post bypass surgery; areas of fibrosis in both lower lung zones
CX 5-2	11/2/01	Bellotte/B	1/2; t/q; 6 zones; status post coronary artery bypass graft; pulmonary fibrosis
CX 2-1	4/19/02	Maki	Significant underlying lung disease; left cardiac enlargement and mild prominence of interstitial markings. May be some underlying congestive heart failure
CX 1	3/28/03	Maki	Significant pulmonary fibrosis with COPD and emphysematous change; chronic bronchitis is also likely present
CX 5-1	7/7/03	Bellotte/B	1/2; q/q; 6 zone; status post coronary artery bypass graft; increased interstitial markings, pulmonary fibrosis, left pleural thickening
EX 5	7/7/03	Wiot/BCR, B	Negative for pneumoconiosis; post coronary artery bypass graft; basilar and mid zone interstitial disease, not coal workers' pneumoconiosis. Honeycombing at left base; an irregular opacity primarily in bases. Findings of emphysema. Pneumoconiosis is not a cause of basilar interstitial fibrosis. CWP invariably begins in upper lung fields and is

			primarily a rounded opacity. Only when the disease progresses does it move to the mid and lower lung fields.
EX 3	11/5/03	Zaldivar/B	Negative for pneumoconiosis; post coronary artery bypass surgery; combined bullae and irregular opacities with honeycombing of pulmonary fibrosis
EX 5	11/5/03	Wiot/BCR, B	Negative for pneumoconiosis; post coronary artery bypass graft; basilar and mid zone interstitial disease, not coal workers' pneumoconiosis. Honeycombing at left base; an irregular opacity primarily in bases. Findings of emphysema. Pneumoconiosis is not a cause of basilar interstitial fibrosis. CWP invariably begins in upper lung fields and is primarily a rounded opacity. Only when the disease progresses does it move to the mid and lower lung fields.

Existence of Pneumoconiosis

The Regulations define pneumoconiosis broadly, as "a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment." 20 C.F.R. § 718.201. The Regulations' definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Clinical pneumoconiosis comprises:

> Those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silico-tuberculosis, arising out of coal mine employment.

Id. Legal pneumoconiosis, on the other hand, includes "any chronic lung disease or impairment and its sequelae" if that disease or impairment arises from coal mine employment. *Id.* A claimant's condition "arises out of coal mine employment" if it is a "chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by,

dust exposure in coal mine employment." *Id.* Finally, the Regulations reiterate that pneumoconiosis is "a latent and progressive disease" that might only become detectable after a miner's exposure to coal dust ceases. *Id.*

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997). However, this rule is not mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320.

The Regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant had pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)-(4). As there is no autopsy or biopsy evidence and Claimant was not eligible for the presumptions,[2] only chest x-rays, CT scans, and medical opinions can establish the existence of pneumoconiosis in his claim. In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether the miner had established that he had pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

In the April 18, 1988 Decision and Order, Judge Marcellino found the existence of pneumoconiosis pursuant to the x-ray evidence. The evidence consisted of seven readings of five separate x-rays. The August 24, 1973 x-ray was found positive (category 1/0) by a physician whose name could not be discerned. It was also read by Dr. Gaylor, a B-reader and board-certified radiologist, as negative. Both physicians considered the film to be of acceptable quality. However, because I could not ascertain the name or qualifications of the physician who found this x-ray positive, I place no weight on that reading. Rather, I defer to the superior credentials of Dr. Gaylor and consider this x-ray negative. *Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984).

The September 14, 1978 x-ray was found positive (category 1/1) by Dr. Kwak, a board-certified radiologist. Although he did not indicate the quality of the x-ray, it was not reread, so I consider this film positive.

The December 22, 1980 x-ray was found positive by Dr. Goerlich, who is a dually-certified reader. He considered the x-ray to be a quality 2 film, which is satisfactory. Based on Dr. Goerlich's uncontradicted reading of a satisfactory quality x-ray, I consider this x-ray positive for pneumoconiosis.

The August 29, 1984 x-ray was found positive by Dr. Daniel (category 2/2). He graded the film as acceptable. Dr. Gaziano, a B-reader, found the same x-ray to be quality 1 and read

[2] Claimant was ineligible for the § 718.304 presumption because he had not been diagnosed with complicated pneumoconiosis. Claimant did not qualify for the § 718.305 presumption because he did not file this claim before January 1, 1982. Claimant was ineligible for the § 718.306 presumption because he died after the applicable date of March 1, 1978.

the film as completely negative. Dr. Daniel possesses no special credentials for interpreting x-rays. Therefore, I defer to Dr. Gaziano's credentials and consider this x-ray negative.

The most recent x-ray considered by Judge Marcellino was dated December 13, 1984. It was found positive (category 3/3) by Dr. Bassali, a dually-certified reader. Dr. Bassali also adjudged the x-ray to be quality 1. Based on his credentials, his finding the film to be of excellent quality for interpretation, and because the film was not reread, I find this film positive for pneumoconiosis.

There are thirteen additional readings of nine separate x-rays submitted in conjunction with the subsequent claim. The December 13, 1999 x-ray was read by Dr. Shah who is board-certified in radiology. Although there is no notation as to the quality of the film, Dr. Shah found severe COPD and pulmonary fibrosis, but he did not link either condition to coal dust exposure. Therefore, I cannot consider this reading equivalent to pneumoconiosis.

The March 20, 2001, April 2, 2001, and October 23, 2001 x-rays were interpreted by Dr. Amin, a B-reader. These films were produced in a hospital and the quality of each is not noted on the reports of record. Dr. Amin found severe COLD and diffuse honeycombing and interstitial fibrosis in both lungs. Once again, because Dr. Amin did not associate any of these conditions with coal mine employment, I do not find his readings equivalent to pneumoconiosis.

The November 2, 2001 x-ray was read as positive (category 2/2) by Dr. Walker, who possesses no special qualifications for x-ray interpretation. Dr. Walker failed to note the quality of the x-ray. However, it was found to be a quality 1 x-ray and was confirmed as revealing category 2/2 disease by Dr. Hayes, who is both a B-reader and a board-certified radiologist. Dr. Hayes also noted areas of fibrosis in both lower zones. Dr. Bellotte, a B-reader, also interpreted this x-ray and found it positive for pneumoconiosis with a category 1/2 reading. Like Dr. Walker, however, he failed to note the quality of the film when he interpreted it. Because the opinion of the reviewing physicians is unanimous that this x-ray shows pneumoconiosis, and because two of the readers are B-readers, one also being a board-certified radiologist, who found the film quality to be excellent for interpretation, I consider this film positive for the disease.

Dr. David Maki read the April 19, 2002 and March 28, 2003 x-rays. He is neither a B-reader nor a board-certified radiologist. He found significant lung disease, significant pulmonary fibrosis with COPD, and emphysematous changes, but he did not relate any of these conditions to coal dust exposure. Consequently, I cannot consider either x-ray positive for pneumoconiosis.

Dr. Bellotte interpreted the July 7, 2003 x-ray as positive for pneumoconiosis, with a 1/2 reading. He noted pulmonary fibrosis, as well. Dr. Bellotte is a B-reader. This x-ray was reread by Dr. Wiot, a dually-certified reader, who found the film negative for pneumoconiosis. Dr. Wiot noted interstitial disease in the mid and lower zones, with honeycombing in the left base. He added that pneumoconiosis is not a cause of basilar interstitial fibrosis, adding that pneumoconiosis invariably begins in the upper lung zones. Both physicians graded the film quality as 1. In determining how to evaluate the different readings, I defer to Dr. Wiot's superior credentials and, thus, consider this individual x-ray negative. *Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984).

The final x-ray of record was taken November 5, 2003 and read by Dr. Zaldivar, a B-reader[3], and Dr. Wiot, a dually-certified reader. Both found the film to be of excellent quality for interpretation purposes. Dr. Zaldivar found the film negative for pneumoconiosis. Rather, he saw bullae and irregular opacities with the honeycombing of pulmonary fibrosis. Dr. Wiot also did not find pneumoconiosis. He made the same findings as when he read the July 7, 2003 x-ray. Based on the shared view of these physicians, their qualifications as readers, and the high quality of the x-ray, I consider this individual x-ray negative.

In summary, there are a total of twenty readings of fifteen separate x-rays taken between August 1973 and November 2003. There are nine positive readings, five negative readings, and six other readings that cannot be considered positive for pneumoconiosis. I place no weight on the six interpretations that cannot be considered positive for pneumoconiosis. These films are dated 12/13/99; 3/20/01; 4/2/01; 10/23/01; 4/19/02; and 3/28/03. They were taken in hospital settings and were not specifically interpreted for the presence or absence of pneumoconiosis, nor were any of them reread. I do not infer these x-rays to be negative for pneumoconiosis, but neither can I find them positive for the disease. As a consequence, I find that their probative value is low. *See Marra v. Consolidation Coal Co.*, 7 BLR 1-216 (1984), allowing the administrative law judge the *discretion* to infer that an interpretation which does not mention the presence of pneumoconiosis is negative.

Of the nine positive readings, I place no weight on the August 1973 x-ray because the reader's surname is illegible and it is impossible to ascertain his credentials. Thus, I am left with eight positive readings and five negative readings. While three of the positive readings were silent as to film quality, I assume that silence indicates the x-rays were of acceptable quality. *Auxier v. Director, OWCP*, 8 BLR 1-109 (1985). All other films were found to be either quality 1 or 2, both of which are acceptable for interpretation purposes. I am also not bothered by the fact that four of the positive readings were of films dated between 1978 and 1985. The Board has held that the "later evidence" rule should not be applied mechanically to demonstrate an "improvement" in the miner's condition because pneumoconiosis is progressive and irreversible. *Bailey v. U.S. Steel Mining Co.*, 21 BLR 1-152 (1999) (en banc on recon.). The Fourth Circuit, under whose jurisdiction this claim arises, rejected in *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992) the application of the "later evidence" rule where the evidence shows improvement of pneumoconiosis over time, that is, when later x-rays were negative and earlier studies were interpreted positively.

[3] In my prior opinion, I found that Dr. Zaldivar was not a B-reader at the time he interpreted the 11/5/03 film. The Board directed that, on remand, I discuss Dr. Zaldivar's deposition testimony regarding his qualifications. In his deposition of January 20, 2004, Dr. Zaldivar testified that he first became certified as a B-reader in 1976 and continued to be recertified every four years thereafter. (EX 12, p. 5). The 1998 curriculum vitae that was admitted into evidence states that he was first certified in 1976 and was then recertified in 1978, 1985, 1989, and 1993, leaving it unclear whether Dr. Zaldivar was a B-reader in November 2003. (EX 4). However, the NIOSH Comprehensive Reader List maintained by the Department of Labor and found at www.oalj.dol.gov, shows that Dr. Zaldivar was a certified B-reader from December 1, 2001 to November 30, 2005. I take official notice of this fact and find that Dr. Zaldivar was a B-reader when he interpreted the November 5, 2003 x-ray on the same date the film was taken.

When considering the qualifications of the readers, two B-readers and four dually-certified readers found the x-rays positive. Two B-readers and three dually-certified readers found the x-rays negative, thus giving the slight numerical edge to the positive readings, which is consistent with the overall numerical superiority of positive to negative readings.

Based upon my analysis of each individual x-ray, my consideration of the quality and quantity of the films of records, my determination that the "later evidence" rule is not applicable here, and my consideration of the qualifications of the physicians who provided readings, I find that Claimant had established, by a slight preponderance of the evidence, the existence of pneumoconiosis pursuant to § 718.202(a)(1).

Evidence Under § 718.202(a)(4)

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds that the miner suffers from pneumoconiosis. 20 C.F.R. § 718.202(a). Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 BLR 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an ALJ may find the report to be not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 BLR 1-1130 (1984). A medical opinion is not sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 BLR 1-368 (1983).

In the Decision and Order of September 24, 2004, I found and concluded:

> In connection with the original claim, the record contains the opinions of Drs. Daniel, Rertenwald and Hayes, and Jacobson. All found the existence of pneumoconiosis. In conjunction with the subsequent claim, Drs. Walker, Bellotte, Olson, and Rasmussen diagnosed pneumoconiosis. Only Dr. Zaldivar did not. I find the opinions of the physicians who found the existence of pneumoconiosis to be supported by the overall x-ray evidence. The opinions of Drs. Walker, Bellotte, Olson, and Rasmussen are well documented and reasoned. Drs. Bellotte and Rasmussen had the opportunity to review all the documentary evidence of record, thereby providing them with a broad base from which to draw their conclusions. Consequently, I place great weight on these opinions.
>
> On the other hand, I discount Dr. Zaldivar's opinion on this issue because he stated that there was no evidence to justify a diagnosis of pneumoconiosis when, in fact, nine of the x-ray readings he reviewed were positive for the disease. This fact belies his conclusion. Consequently, I do not consider his opinion well reasoned, and I discount it.
>
> The CT scan evidence shows a diagnosis of end-stage pneumoconiosis by Dr. Patel, and a reading of no pneumoconiosis by Dr. Wiot. Both physicians are

> board-certified radiologists. However, Dr. Wiot opined that coal workers' pneumoconiosis is not a cause of basilar interstitial fibrosis, and I find this statement to be contrary to the medical article cited by Dr. Rasmussen. Dr. Rasmussen opined that it can be a cause and cited to an article that at least suggests further study of the issue. Even Dr. Bellotte allowed that there may be a connection between the two. For this reason, I do not find Dr. Wiot's CT scan interpretation to be as credible as Dr. Patel's. Therefore, I consider the CT scan evidence supportive of a finding of pneumoconiosis. I also find that the medical opinion evidence establishes the existence of pneumoconiosis.
>
> Weighing all the evidence together, I find that the positive x-ray interpretations, when combined with Dr. Patel's CT scan reading and the overall medical opinion evidence, establishes the existence of pneumoconiosis.

The Board held that I did not accurately characterize the relevant evidence concerning the CT scan. Specifically, the Board pointed out that Dr. Bellotte's testimony was mischaracterized and that I failed to acknowledge Dr. Zaldivar's statement about the medical article relied upon by Dr. Rasmussen, whose opinion was given greatest weight.

Further review of Dr. Bellotte's deposition reveals that he disagreed that diffuse interstitial pulmonary fibrosis is more common among coal miners than the general population. He emphasized that the McConnochie article stated that it is unknown whether pulmonary fibrosis is related to coal dust inhalation. According to Dr. Bellotte, the article documents incidents of pulmonary fibrosis in coal miners but does not stand for the proposition that coal dust exposure or pneumoconiosis causes diffuse interstitial pulmonary fibrosis. (EX 11). In Mr. Stephenson's case, Dr. Bellotte opined that coal mine dust inhalation was not a cause of his pulmonary fibrosis.

Dr. Zaldivar also addressed the McConnochie article in his deposition. (EX 12). He also stated that the authors of the article did not assert that coal workers' pneumoconiosis resulted in pulmonary fibrosis. Rather, the authors found coal miners with pulmonary fibrosis and suggested they needed to be further studied. He opined that the miner's pulmonary fibrosis was not the result of his coal dust exposure and referred to a monograph by the Centers for Disease Control which does not even include pulmonary fibrosis as a differential diagnosis of coal workers' pneumoconiosis.

Closer consideration of the deposition testimony of Dr. Bellotte and Dr. Zaldivar affects only my analysis of the CT scan evidence. I reaffirm my conclusions that the opinions of Drs. Walker, Bellotte, Olson, and Rasmussen – that Mr. Stephenson had pneumoconiosis – merit greater weight than Dr. Zaldivar's contrary opinion because they are supported by the x-ray evidence. Dr. Zaldivar's conclusion that there is no evidence to justify the diagnosis is clearly belied by the preponderance of x-ray evidence to the contrary. However, my consideration of the CT scan evidence has changed.

Dr. Wiot's opinion that coal workers' pneumoconiosis is not a cause of basilar interstitial fibrosis is **not**, according to Drs. Bellotte and Zaldivar, contrary to the McConnochie article.

They testified that the article makes no such connection but merely presents cases of coal miners who happen to have pulmonary fibrosis. Dr. Rasmussen offered that the article at least suggests further study of the matter. Consequently, I find that Dr. Wiot's interpretation of the CT scan is not controverted by the McConnochie article. As a consequence, I find that the interpretations of the CT scan evidence are directly contradictory; Dr. Patel found pneumoconiosis while Dr. Wiot did not. Dr. Bellotte testified that he did not find the CT scan evidence helpful in his decision of whether the miner has coal workers' pneumoconiosis. He found it showed bullous emphysema that is classically due to smoking but he could not rule out that some of the changes were due to pneumoconiosis. Accordingly, I find that the CT scan evidence is insufficient, by itself, to establish the existence of pneumoconiosis.

Upon consideration of all the medical evidence under § 718.202(a), I find that the x-ray evidence and medical opinion evidence is more persuasive in combination than the CT scan evidence. For the reasons articulated above, I conclude that Claimant had established, by a preponderance of the evidence, the existence of pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Total Disability Causation

The Board directed that if I found the existence of pneumoconiosis on remand, I must then reconsider the evidence to determine whether Claimant had established that he was totally disabled due to pneumoconiosis in accordance with Section 718.204(c). Specifically, the Board pointed out that both Dr. Zaldivar and Dr. Bellotte had not found that the authors of the McConnochie article had found a causal relationship between coal dust exposure and pulmonary fibrosis. The Board also found that I did not explain my rationale for according greatest weight to Dr. Rasmussen's opinion particularly in light of my finding that he is not as expert as Drs. Bellotte and Zaldivar.

Claimant must establish by a preponderance of the evidence that his total disability was due to pneumoconiosis. *Baumgartner v. Director, OWCP*, 9 BLR 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 BLR 1-4, 1-6 (1986) (*en banc*). The amended Regulations require that the pneumoconiosis be a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Section 718.204(c)(1) sets forth that pneumoconiosis is a substantially contributing cause of disability if it either (1) has a material adverse effect on the miner's respiratory condition or (2) materially worsens a totally disabling respiratory impairment caused by a disease unrelated to coal mine employment. In *Tennessee Consolidated Coal Co. v. Director, OWCP*, 264 F.3d 602 (6th Cir. 2001), the Court of Appeals for the Sixth Circuit interpreted the "materially worsens" standard, finding that the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even absent any coal dust exposure would not preclude entitlement to benefits if pneumoconiosis "materially worsens" this condition. Furthermore, physicians are not required to precisely determine the percentages of contribution to total disability. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

Dr. Bellotte opined that Mr. Stephenson's total disability was due to coronary artery disease and congestive heart failure. He found no pulmonary or respiratory impairment related to pneumoconiosis. He did not believe that coal dust exposure caused Mr. Stephenson's

interstitial pulmonary fibrosis. In fact, he opined that Claimant would be as disabled even if he had never worked in the coal mines because smoking accounted for his cardiovascular disease and the emphysema he displayed is particularly associated with smoking. Dr. Olson did not address the etiology of the miner's disability but did express that the Claimant's pulmonary fibrosis could be due to pneumoconiosis. Dr. Zaldivar felt that the Claimant was disabled due to pulmonary fibrosis unrelated to coal mine employment and coronary artery disease. Dr. Rasmussen opined that the miner's total disability was due to smoking, coal dust exposure, and interstitial fibrosis.

The opinions of the four physicians who examined Claimant in connection with his original claim must also be considered. Drs. Rertenwald and Hayes examined the miner in December 1980, and Dr. Jacobson evaluated him one month later in January 1981. The Claimant was still working as a coal miner at this time. Drs. Rertenwald and Hayes found no impairment, and Dr. Jacobson did not address the issue of impairment. Dr. Daniel saw the miner in August 1984, four months after he left coal mine employment. The physician found no evidence of significant pulmonary dysfunction and believed that the miner should be able to perform his usual work activities. Because these opinions are so remote in time — at least twenty years old — and pneumoconiosis can be progressive in nature, I place no weight on these early opinions. *See Bates v. Director, OWCP*, 7 BLR 1-113 (1984) (more recent report of record entitled to more weight than reports dated eight year earlier).

Based on the opinions of Drs. Bellotte, Olson, Zaldivar, and Rasmussen, the key question is whether Claimant's pneumoconiosis was a substantially contributing cause of Claimant's disability. Therefore, I must determine whether Claimant's pneumoconiosis (1) had a material adverse effect on his pulmonary fibrosis or (2) had materially worsened a totally disabling respiratory impairment caused by a disease unrelated to coal mine employment, such as his cardiac disease.

While Dr. Olson was the miner's treating physician, having first seen him in 1999 and having treated him about every three to six months for a variety of ills, he did not express much understanding of pneumoconiosis. In fact, he stated in his deposition that he would defer to pulmonary specialists on any issues regarding that disease and other pulmonary diseases. He testified that he did not know the cause of hypoxemia or whether pneumoconiosis is a latent and progressive disease. Thus, despite Dr. Olson's status as the miner's treating physician, I do not give his opinion controlling weight. 20 C.F.R. § 725.104(d). Furthermore, Dr. Olson stated that he relied upon the interpretations of those conducting x-rays and pulmonary function studies; he did not render his own opinion based on those results. For these reasons, I do not consider Dr. Olson's report to be well reasoned. Lastly, because Dr. Olson expressed his opinion in indefinite terms — "could be due to pneumoconiosis" — his opinion is entitled to less weight. *Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). Consequently, I place no weight on his opinion in regard to this issue.

Dr. Rasmussen's opinion is well documented. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). He is board-certified in internal medicine and forensic medicine. These credentials lend some degree of credence to his determinations. He also reviewed all the medical evidence of record, thus providing him with a broad base of data from which to draw his conclusions.

Because he is not board-certified in pulmonary disease, I do not consider him to be as expert in the field of pulmonary medicine as Dr. Bellotte and Dr. Zaldivar. Moreover, he failed to mention the role of the miner's significant heart disease (myocardial infarction, angioplasties, CABG, coronary artery disease) played in his total disability and symptoms of respiratory impairment such as shortness of breath and coughing, whereas Dr. Bellotte felt that cardiovascular disease and bullous emphysema explained Claimant's disability.

Dr. Rasmussen strongly relied upon the McConnochie article for his belief that pulmonary fibrosis is much more common among coal miners than those in the general population. In the face of the shared yet independent opinions of Drs. Bellotte and Zaldivar — that the article set forth that some coal miners have pulmonary fibrosis but that there is no causal link between the two — Dr. Rasmussen's defense of his reliance on the article is not altogether persuasive. The article provides tenuous support for his conclusion, at best, for Dr. Rasmussen concluded that the article's failure to assert a known causative mechanism in no way excludes coal mine dust as a causative factor in the case of interstitial fibrosis in coal miners. Because Claimant had a thirty-year exposure to coal mine dust, and some x-rays have been read as positive for coal workers' pneumoconiosis, Dr. Rasmussen reasoned that Claimant's pulmonary fibrosis should not be deemed "idiopathic;" it should be considered due to coal dust exposure, at least in part. However, Dr. Rasmussen's reasoning is directly contradicted by Dr. Bellotte, who, despite identifying chronic infections, asthma, and congestive heart failure as etiologies for the interstitial fibrosis, nonetheless labeled the disease "idiopathic." Dr. Bellotte further ruled out coal dust exposure as a cause because of the lack of medical literature to support that conclusion. Because Dr. Rasmussen's credentials in the field of pulmonary medicine do not equal either Dr. Bellotte's or Dr. Zaldivar's; because he failed to address the role of the miner's significant heart disease as the cause of disability and respiratory impairment; and because the McConnochie article on which he relied fails to provide even specious support for his position, I place diminished weight on Dr. Rasmussen's opinion on this issue.

I find Dr. Bellotte's opinion to be persuasive. He examined the miner, reviewed additional medical evidence, and maintains excellent credentials in the area of pulmonary disease. He explained how Claimant's pulmonary function studies are consistent with congestive heart failure and pulmonary fibrosis: impaired diffusion capacity with normal ventilation. Dr. Zaldivar bolstered this opinion. Dr. Bellotte also pointed out that some of the medications the miner was taking for his heart ailments can cause respiratory symptoms such as cough, wheeze, and dyspnea.

Dr. Bellotte also illustrated why the Claimant's symptoms and objective medical evidence are consistent with pulmonary fibrosis but not pneumoconiosis: (1) according to the CT scan, lesions are found in the bases of the lungs as opposed to the upper portion of the lungs; (2) the CT scan showed honeycombing; (3) the 1984 x-ray was negative; (4) there is no medical literature making a connection between pulmonary fibrosis and pneumoconiosis or coal mine employment; (5) repeated infections, asthma, and congestive heart failure are reasonable suspects as the cause of the pulmonary fibrosis; and (6) normal pulmonary function studies long after the miner's 1984 retirement.

I note that Dr. Bellotte sought support in the August 29, 1984 x-ray that was found negative by Dr. Gaziano, a B-reader, and the CT scan that was found negative by Dr. Wiot. This is curious because a December 13, 1984 x-ray was found positive by Dr. Bassali, a dually-certified reader, the September 14, 1978 and December 22, 1980 x-rays were interpreted as positive for pneumoconiosis, and Dr. Patel believed the CT scan showed end-stage pneumoconiosis. Still, Dr. Bellotte himself diagnosed simple pneumoconiosis, so his reliance on the negative x-ray and CT scan evidence does not completely lessen the weight to be given his opinion regarding etiology.

More troubling are two deposition statements that require interpretation. When asked about Dr. Rasmussen's contention that interstitial pulmonary fibrosis (IPF) is more common among coal miners than the general population, Dr. Bellotte responded:

> I would disagree with that. I would just say that it occurs in the general population. And since West Virginia has a higher population of coal miners, we may see it more frequently. But otherwise, I wouldn't think that would hold true across the United States.

(EX 11, p. 25). After further consideration of this testimony, I no longer find that the statement acknowledges that there may be a nexus between coal mining and IPF. I now believe Dr. Bellotte meant that because there are more coal miners per capita in West Virginia than in other states, they make up a larger percentage of the general population of that state and, therefore, people presenting with IPF in West Virginia are more likely to be coal miners than people presenting with the same disease in other states.

At another part of the deposition, Dr. Bellotte explained how he can rule out coal mine dust as a cause of IPF:

> A. Well, because when you look over the data we have no data to suggest that it occurs with more frequency in patients who have coal workers' pneumoconiosis. What we're saying here is if you work in a coal mine it won't protect you from developing pulmonary fibrosis, what we're saying is nobody is protected from having pulmonary fibrosis.
>
> Q. Is it also proper to state that if you work in the coal mines, exposure in the coal mines will cause pulmonary fibrosis with any more frequency?
>
> A. Based on the information we have to this point, yes.

(EX 11, p. 30). The second answer directly contradicts the prior answer, but the first answer is consistent with all other parts of Dr. Bellotte's deposition. Accordingly, I conclude that the word "not" must have been omitted from the subsequent question or that Dr. Bellotte interpreted the question as having been asked in the negative. As a consequence, because of Dr. Bellotte's expertise in pulmonary diseases, the support of medical literature, and his explanations for the cause of Mr. Stephenson's pulmonary fibrosis and disability, I place great weight on his opinion.

Dr. Zaldivar is board-certified in internal medicine and pulmonary disease. His expertise in pulmonary medicine merits deference. His opinion is well documented and he has also considered all the medical evidence of record, thereby providing him with a clear picture of the miner's health over time. Like Dr. Bellotte, he stated that honeycombing found on the x-rays and CT scan is consistent with pulmonary fibrosis and not pneumoconiosis. Both also asserted that a reduced diffusion capacity is typical of pulmonary fibrosis.

Dr. Zaldivar, however, is the only physician who opined that Claimant did not suffer from CWP. The Fourth Circuit has held that a medical opinion that finds that a claimant does not have CWP "can carry little weight" in assessing the etiology of the miner's total disability "unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation does not rest upon h[is] disagreement with the ALJ's finding as to either or both of the predicates . . . in the causal chain." *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). In this case, Dr. Zaldivar assumed the existence of pneumoconiosis and went on to state that his opinion regarding total disability causation would not change. Dr. Zaldivar strongly asserted that CWP never causes pulmonary fibrosis and explained that the Centers for Disease Control does not include pneumoconiosis as part of the differential diagnosis for pulmonary fibrosis. Dr. Bellotte's interpretation of the medical literature seems to support Dr. Zaldivar's belief. Based on Dr. Zaldivar's credentials, his willingness to assume the existence of pneumoconiosis, and his reliance on medical literature that supports his position, I place great weight on his opinion.

Based on the foregoing analysis, I find that Claimant failed to establish, by a preponderance of the evidence, that pneumoconiosis was a substantially contributing cause of his disability in that he had not shown that the disease had a material adverse effect on his respiratory condition.

Conclusion

As Claimant failed to establish all elements of entitlement, I conclude that he did not establish entitlement to benefits under the Act.

Attorney's Fees

The award of attorney's fees, under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

ORDER

It is ordered that the claim of BEN L. STEPHENSON for benefits under the Black Lung Benefits Act is hereby DENIED.

A

MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).